

卷之三

FIG. 1

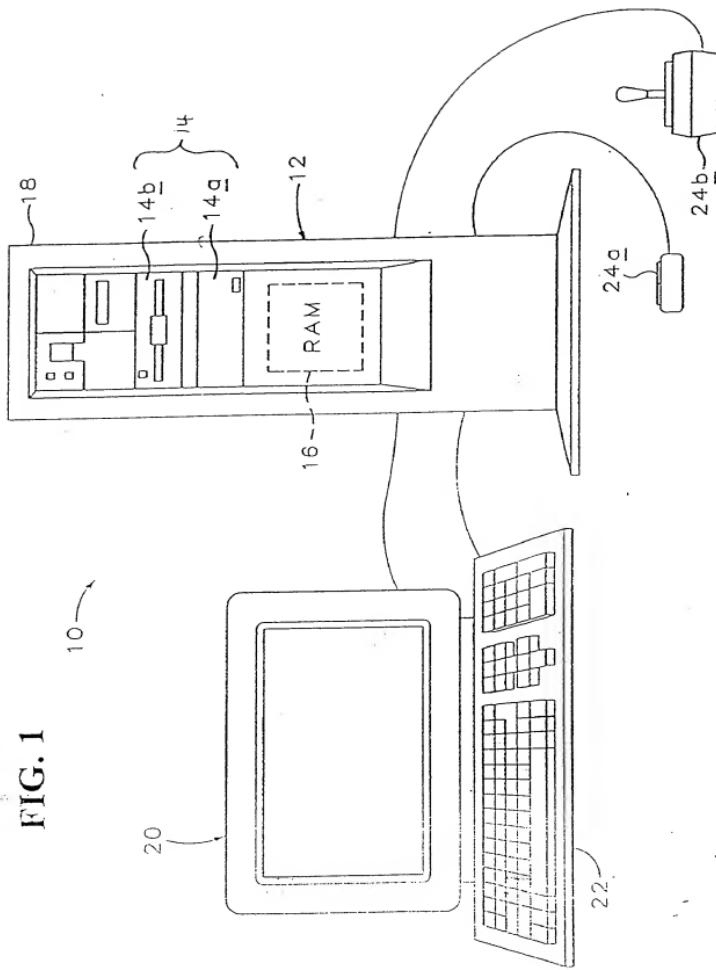


Fig. 2

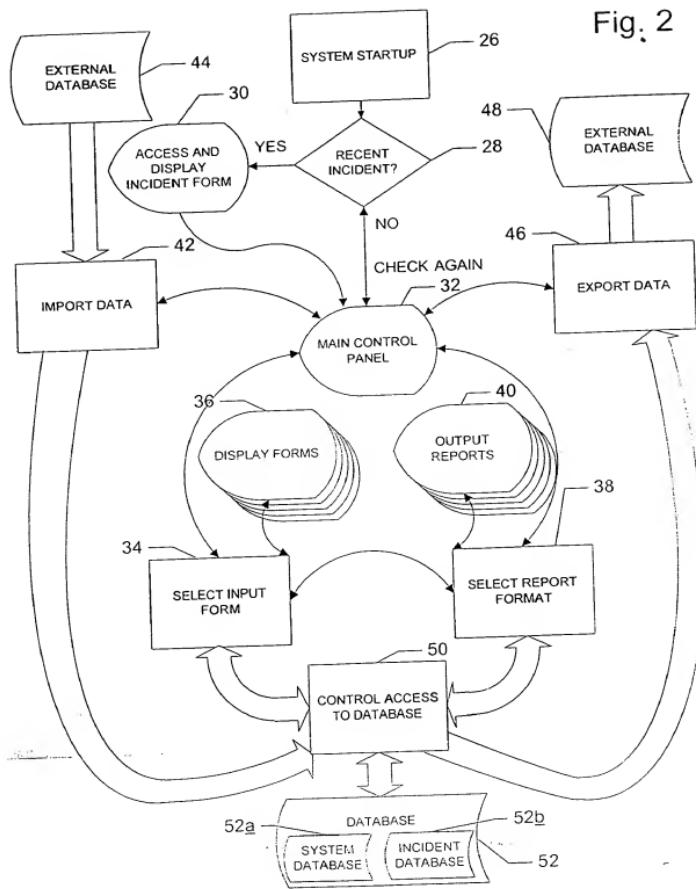


FIG. 3

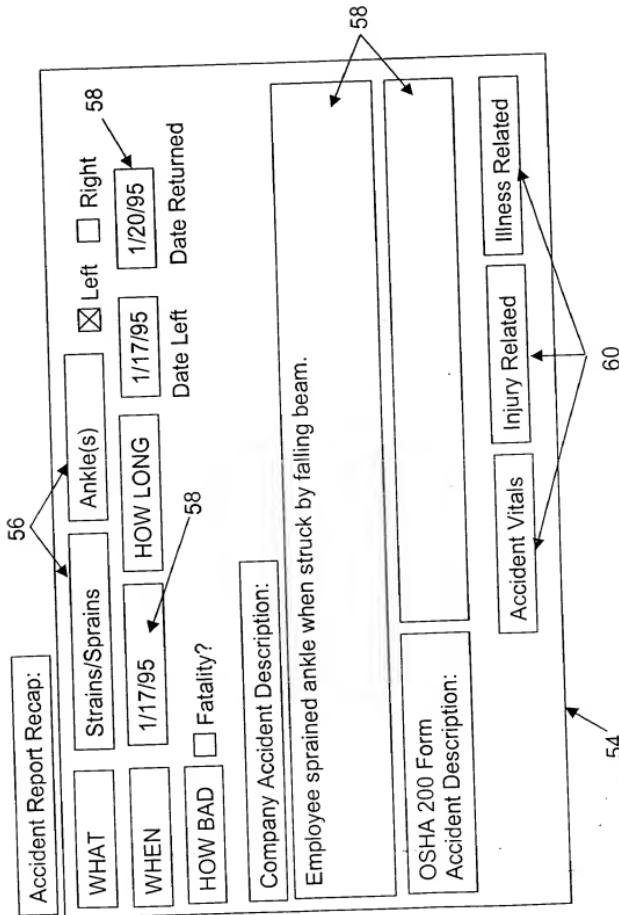


FIG. 4A

Bureau of Labor Statistics Log and Summary of Occupational Injuries and Illnesses					
<b>NOTE:</b> This form is required by Public Law 91-596 and must be kept in the establishment for 5 years. Failure to maintain and post can result in the issuance of citations and assessments of penalties. (See <i>penalty requirements on the other side of form</i> .)					
<b>RECORDABLE CASES:</b> You are required to record information about every occupational death, every nonfatal occupational illness, and those nonfatal occupational injuries which involve one or more of the following: loss of consciousness; restriction of work or motion, transfer to another job, or medical treatment (other than first aid). (See <i>definitions on the other side of form</i> .)					
Case or File Number	Employee's Name	Occupation	Department	Description of Injury or Illness	
Enter a nonduplicating number which will facilitate comparisons with supplementary records.	Enter first name or initial, middle initial, last name.	Enter regular job title, not activity performing when injured or at onset of illness. In the absence of a formal title, enter a brief description of the employee's duties.	Enter department in which the employee is regularly employed or a workplace to which employee is assigned, even though temporarily working in another department at the time of the injury or illness.	Enter a brief description of the injury or illness and indicate the part or parts of body affected.	
(A)	(B)	(C)	(D)	(E)	(F)
					PREVIOUS PAGE TOTALS
					TOTALS (Instructions on other side of form)

FIG. 4B

OSHA Form 200

U.S. Department of Labor

For Calendar Year 19 \_\_\_\_\_ Page \_\_\_\_\_ of \_\_\_\_\_

Page 01

108

January 1

261

# FIG. 5

Start Year	1994
End Year:	1995
Co:	
Locale	
Dept:	

70

## Accident Analysis – By Nature of Injury

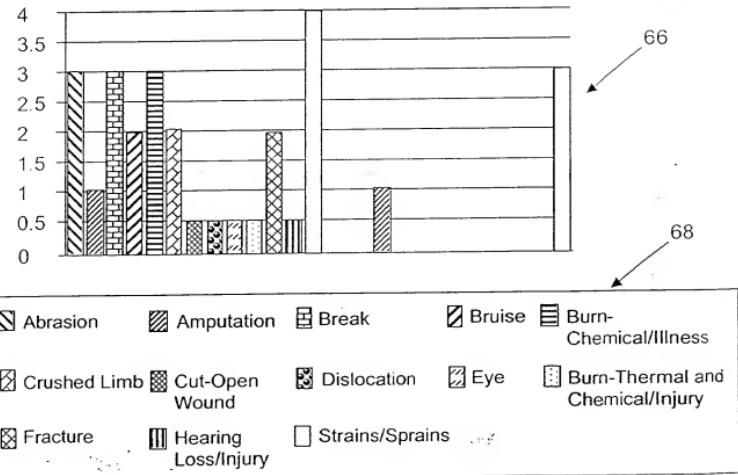


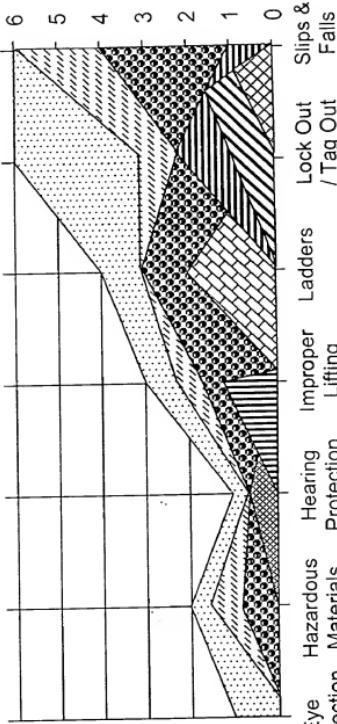
FIG. 6

Year:	1994
Co:	
Locale	
Dept:	

66

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Accident Type



68

<input checked="" type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input type="checkbox"/> April	<input type="checkbox"/> May	<input type="checkbox"/> June
<input type="checkbox"/> July	<input checked="" type="checkbox"/> August	<input checked="" type="checkbox"/> September	<input checked="" type="checkbox"/> October	<input checked="" type="checkbox"/> November	<input checked="" type="checkbox"/> December

FIG. 7

Year:	1994
Co:	
Locale	
Dept:	

70

Accident Analysis – By Day of the Week

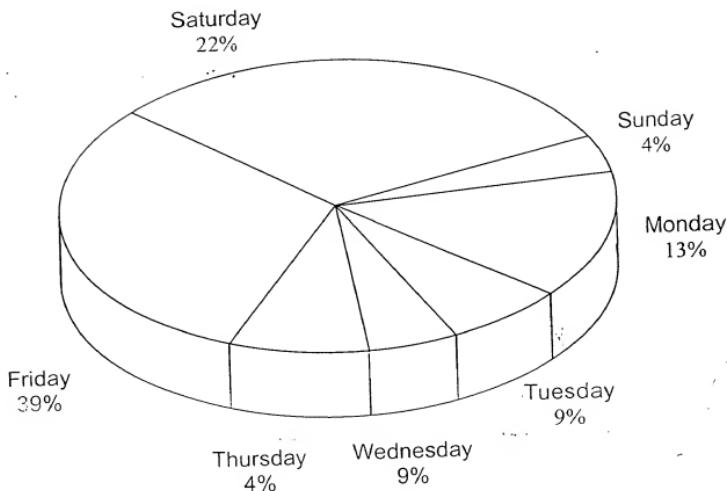


Fig. 8

SOS Report – Status Report

Report Date

INITIAL REPORT				INVESTIGATION				
NATURE	DATE	C. ACTION	SUPVR.	ACTION ND	CAUSE	P. ACTION	ACKNOWL	COMPL TO
GRANT NEAR MISS ON 3/14/94								
CHASE UNSAFE ACT ON 5/1/94								
WALLER BREAK ON 5/14/94								
COLE UNSAFE ACT ON 5/14/94								
JEFFERSON ON 1/18/95								

REPORT ID INFO

1069
1901
10073
1005
1698

74

72

Fig. 9

SAFESTAR – Master List All

Participants (Alpha)

REPORT DATE: 11-JUL-95

Vital Statistics:	
NAME:	BOYNTON, SUSAN
ADDRESS:	13201 NE 44TH STREET #14
CITY/ST/ZIP:	VANCOUVER, WA 98682
PHONE:	206-896-9726
Employment Information:	
SOC. SEC. #	540962944
D.O.B.:	8/3/64
HIRE/DI/LOE:	5/12/76 - 19 YRS 2 MOS
DPT# NAME	3 - TRUCKING

Vital Statistics:	
NAME:	GRANT, LOU
ADDRESS:	497 WRITERS DR.
CITY/ST/ZIP:	PERIODICAL, NE 97640
PHONE:	402-555-2222
Employment Information:	
SOC. SEC. #	789879742
D.O.B.:	12/2/40
HIRE/DI/LOE:	6/14/90 - 5 YRS 1 MOS
DPT# NAME	5 - RETAIL

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Vital Statistics:	
NAME:	CHASE, CHEVY
ADDRESS:	499 FOX BLVD.
CITY/ST/ZIP:	HOLLYWOOD, CA 76004
PHONE:	310-655-7324
Employment Information:	
SOC. SEC. #	545069823
D.O.B.:	5/17/47
HIRE/DI/LOE:	4/11/78 - 17 YRS 3 MOS
DPT# NAME	2 - OFFICE

Vital Statistics:	
NAME:	JEFFERSON, GEORGE
ADDRESS:	805 HIGH RISE BLVD
CITY/ST/ZIP:	NEW YORK, NY 80754
PHONE:	201-555-6890
Employment Information:	
SOC. SEC. #	773901320
D.O.B.:	8/13/58
HIRE/DI/LOE:	7/18/88 - 7 YRS 0 MOS
DPT# NAME	1 - MANUFACTURING

Fig. 10

Accident Report Synopsis – By Period

REPORT DATE: 11-JUL-95

Report Start 01-Jan-94

Report End

01-Jan-95

Month January

Department

1 - Manufacturing

INJURY DATE	LAST NAME	FIRST	SSN	NATURE OF INJURY	ACCIDENT TYPE	LOE	TIME IN DEPT
1/14/94	KEATON	BUSTER	813902231	Thermal & Chemical	LOCK OUT / TA	1 YRS-16 MOS	

ACCIDENT DESCRIPTION	WHEN A DOOR TO THEM MAIN FURNACE WAS OPENED ACCIDENTALLY, EMPLOYEE'S RIGHT ARM WAS BURNED WHEN THE FURNACE LOCK-OUT / TAG-OUT SWITCH FAILED TO ENGAGE.
CORRECTIVE ACTION TAKEN	HAVE SHUT DOWN THE FURNACE AND ORDERED REPAIRS MADE. ALSO, HAVE ADVISED EMPLOYEE OF CORRECT PROCEDURE.

Month February

Department

1 - Manufacturing

INJURY DATE	LAST NAME	FIRST	SSN	NATURE OF INJURY	ACCIDENT TYPE	LOE	TIME IN DEPT
2/11/94	JEFFERSON	GEORGE	773901320	RN-CHEMICAL/ILLN	HAZARDOUS M	6 YRS-4 MOS	

ACCIDENT DESCRIPTION	EMPLOYEE BURNED ARM WITH ACID.
CORRECTIVE ACTION TAKEN	

INJURY DATE	LAST NAME	FIRST	SSN	NATURE OF INJURY	ACCIDENT TYPE	LOE	TIME IN DEPT
2/11/94	KEATON	BUSTER	813902231	HEARING LOSS/INJURY	HEARING PROT.	2 YRS- MO	

ACCIDENT DESCRIPTION	EMPLOYEE RECEIVED HEARING INJURY DUE TO FAILURE TO WEAR HEARING PROTECTION PROPERLY.
CORRECTIVE ACTION TAKEN	HAVE ADVISED CORRECT PROCEDURE.

FIG. 11

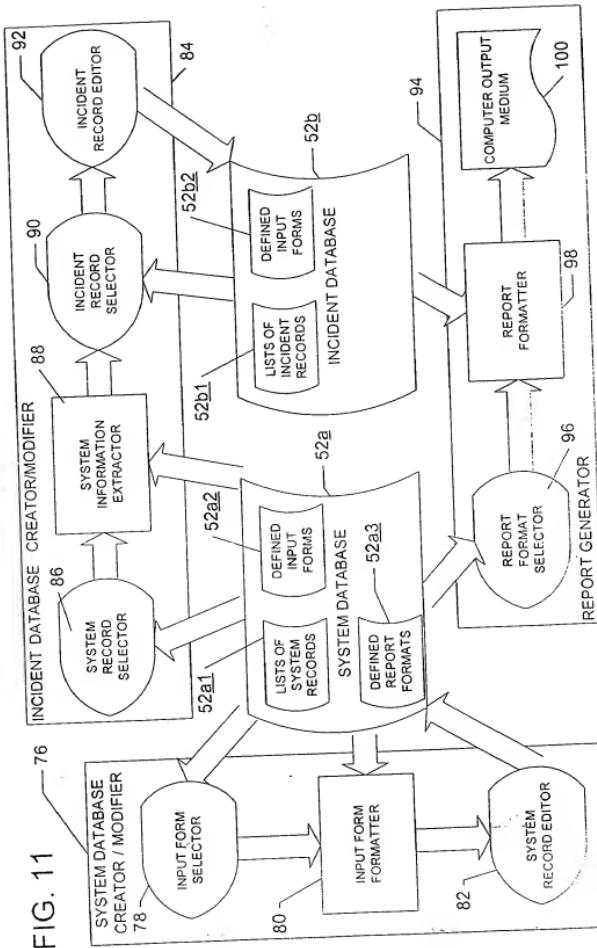


Fig. 15

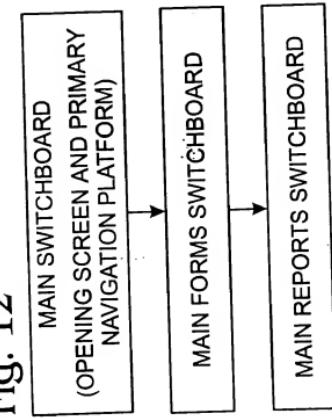
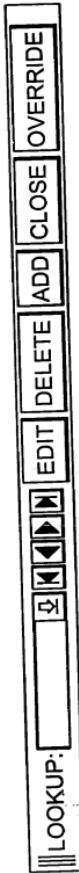


Fig. 13



ACCIDENT NOTICE

Fig. 14

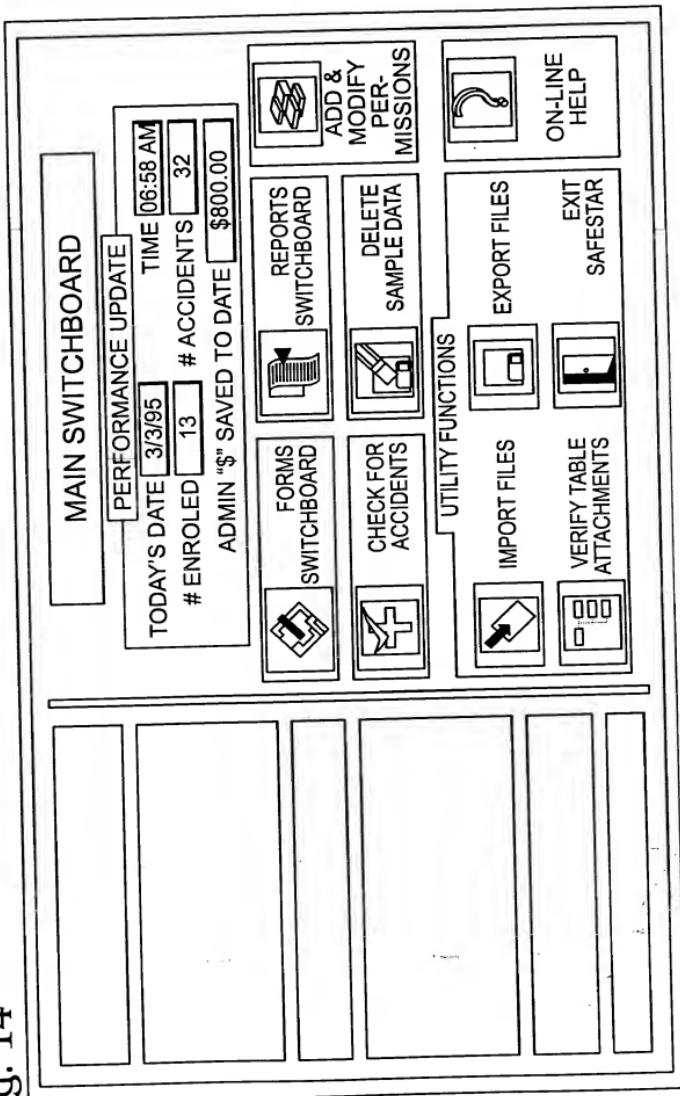
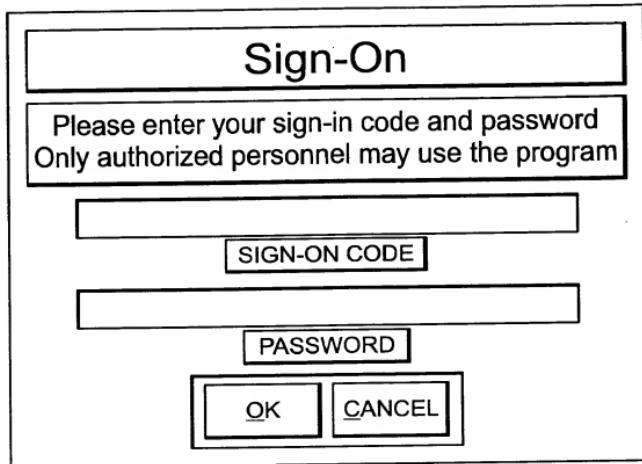


Fig. 16



00110100 01100100 01100100 01100100

Fig. 17

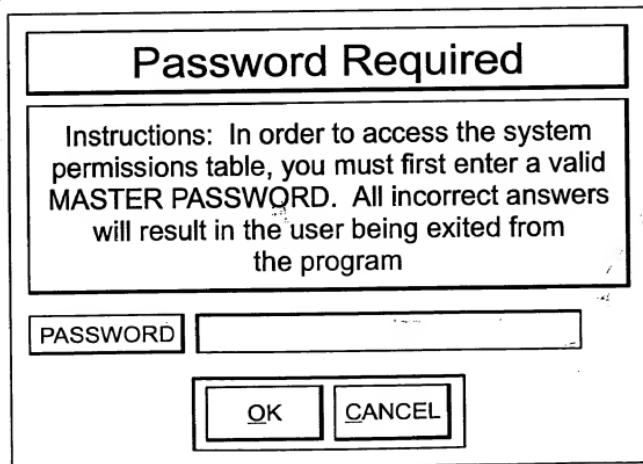


Fig. 18

Sign-On Permissions							
<input type="text"/> LOOKUP: <input type="button"/> EDIT <input type="button"/> DELETE <input type="button"/> ADD <input type="button"/> CLOSE	<input type="button"/> Master Password <input type="button"/> Change Master Password						
<p>Instructions: To Add/Modify/Delete a permissions record, follow these steps</p> <p>Step #1: Sign-On ID= Any letter / number combination that identifies the user (required)</p> <p>Step #2: Password = Any letter / number combination (no spaces) that acts as a secondary security level (e.g. dept. name, file name, etc.)</p> <p>Step #3: Company = Select a specific company name from the list or leave the "*" if unlimited access is desired, (note: the "*" is the default value, if you want to restrict the records for this user to a specific company you will need to replace the "*" with a company name</p> <p>Step #4: Level = Within a given company, Select a specific plant/location # from the list, or leave "*" if unlimited access is desired. (Same note applies as for the company. see Step #3)</p>							
<input type="button"/> Sign-On ID <input type="button"/> Password <input type="button"/> Company <input type="button"/> Level	<table border="1"><tr><td><input type="text"/> *</td><td><input type="text"/> *</td></tr><tr><td><input type="text"/> *</td><td><input type="text"/> *</td></tr><tr><td><input type="text"/> *</td><td><input type="text"/> *</td></tr></table>	<input type="text"/> *					
<input type="text"/> *	<input type="text"/> *						
<input type="text"/> *	<input type="text"/> *						
<input type="text"/> *	<input type="text"/> *						

Fig. 19

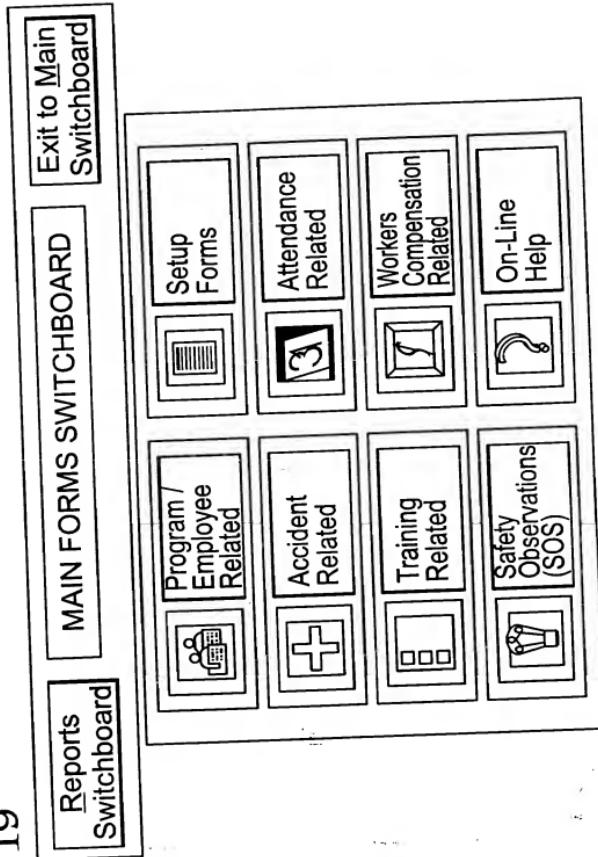


Fig. 20

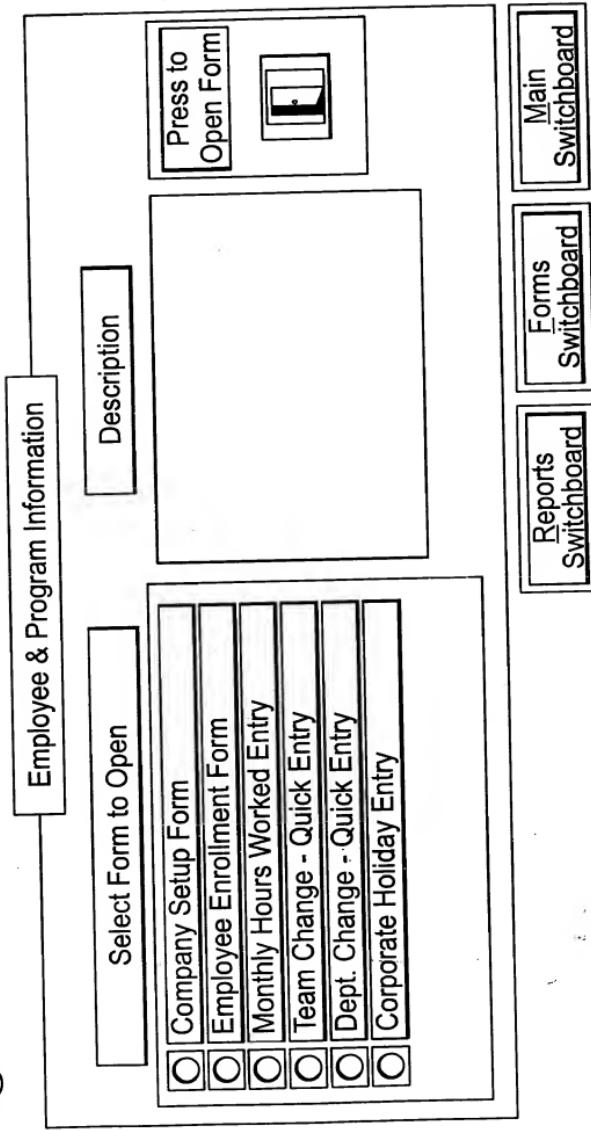


Fig. 21

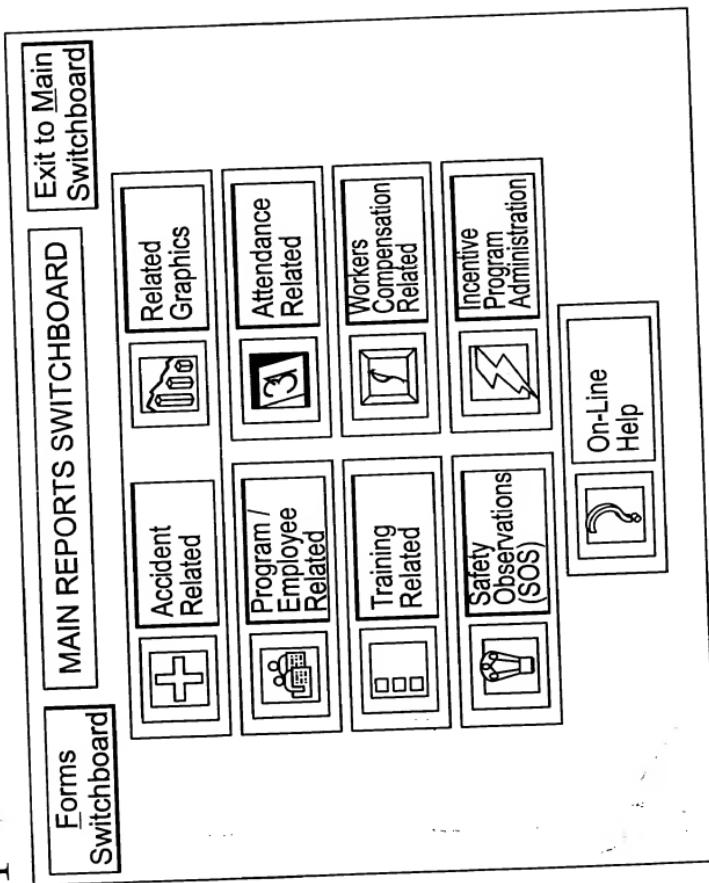


Fig. 22

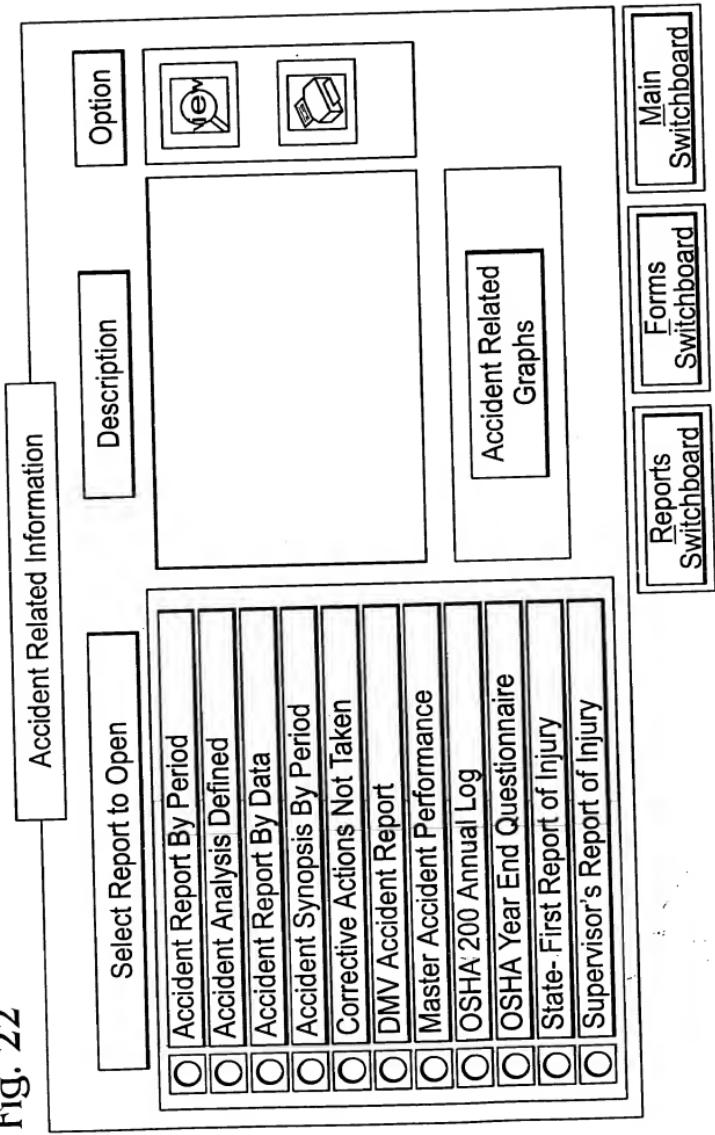


Fig. 23

Company Setup	
<input type="button" value="Save"/>	<input type="button" value="Close"/>
<input type="button" value="Add"/>	<input type="button" value="Open Dept. Setup Form"/>
<input type="button" value="Configure Printer Now"/>	
<input type="text" value="Company Name"/>	
<input type="text" value="Address"/>	
<input type="text" value="City"/>	<input type="text" value="ST"/>
<input type="text" value="ZIP"/>	<input type="text" value="County"/>
<input type="text" value="Telephone"/>	<input type="text" value=""/>
<input type="text" value="Locator #"/>	<input type="text" value="State of Op:"/>
<input type="text" value="999"/>	<input type="button" value=""/>
<input type="text" value="General Nature of Business:"/>	
<input type="text" value="Industry:"/>	<input type="text" value="SIC Code:"/>
<input type="text" value="Primary Hospital:"/>	
<input type="button" value="Page Down"/>	<input type="button" value="Of Record"/>
<input type="button" value="Workers Comp. Insurance Info."/>	<input type="button" value="Page Bottom"/>
<input type="button" value="State Workers Comp. Division Info."/>	

Fig. 24

Body Part - Entry Form

EDIT ADD DELETE CLOSE

Body Part	Code
▶ Abdomen (Includes Internal Organs)	515
Ankle(s)	520
Arm(s)	507
Back (lower, Mid, Upper)	513

Fig. 28

	Counter
LAST	Text
FIRST	Text
SSN	Number
Birthday	Date/Time
LOE	Text
ADJ	Date/Time
Address	Text
City	Text
State	Text
Zip	Number
PHONE	Text
DEPT	Text
Dept Name	Text
Company	Text
Locale	Text
HrlyRate	Number
Occupation	Text
	Text

Fig. 25

Master Enrollment Form	
LOOKUP: <input type="text"/>	<input type="button"/> <input type="button"/> <input type="button"/> <input type="button"/> <input type="button"/> <input type="button"/> NEW <input type="button"/> CLOSE
ID: <input type="text"/>	
Required Only for Network Installations	
Company Name: <input type="text"/>	Location: <input type="text"/>
<input type="text"/>	<input type="text"/>
Last: <input type="text"/>	First: <input type="text"/>
Security #: <input type="text"/>	Date of Birth: <input type="text"/>
Address: <input type="text"/>	City: <input type="text"/>
<input type="text"/>	State: Zip: <input type="text"/>
<input type="text"/>	Phone Number: <input type="text"/>
Debit Code: <input type="text"/>	Office: <input type="text"/> SUPERVISOR <input type="text"/> \$10.00 <input type="text"/> 4/11/78
Dept. Name: <input type="text"/>	Occupation: <input type="text"/> Hourly Rate <input type="text"/> Date of Hire: <input type="text"/>
Complete if Safety Awareness Program will be used and based on "Team" Performance.	
5 <input type="text"/> FALCONS <input type="text"/>	6yrs. 11mos. <input type="text"/>
Team Code: Team Name: <input type="text"/>	Length of Employment: <input type="text"/>

Fig. 26

## ATTENTION! VERY IMPORTANT INFORMATION

You have selected the IMPORT function of the program.

In the event that you continue without completing all of the required steps and are exited out of the program, be assured that your data will not be lost. However, you will need to restart the program.

Note: You should invoke this function only if you have all of the information required and are ready to import the selected ASCII or Excel Spreadsheet file into the program.

In order for this process to be preformed successfully, the file you are preparing to import MUST BE in the EXACT column and date-type order as the Table you are importing into. If this is not done, unrepairable errors may occur and your imported data will not be complete, or may be imported into the incorrect fields of the Table [eg. Social Security # imported into the LAST name column.]

If you are unsure or need additional information, select the requested Table name and press the PRINT TEMPLATE button, before continuing

Table Template Selection	<input type="button" value="PRINT TEMPLATE"/>	<input type="button" value="CANCEL"/>	<input type="button" value="CONTINUE"/>
--------------------------	---	---------------------------------------	---

Fig. 27

Important Setup Parameters	
Select the Source Type of the Data Being Imported	
<input type="radio"/> Text Delimited [ASCII]	<input type="radio"/> Excel Spreadsheet
<input type="radio"/> Lotus WKS file	<input type="radio"/> Lotus WK1 [Version2]
<input type="radio"/> Lotus WK3 [Versions 3 & 4]	
Enter Full Path Name of Data to be Imported	
Enter Name of Table to Import Data Into	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does the First Row Contain Field Names	
<input type="checkbox"/> YES	<input type="checkbox"/> NO
Replace All of the Existing Records?	
<input type="button" value="CLOSE"/>	
<input type="button" value="OK"/>	
Press CLOSE when the import function is completed. (The hour glass will disappear and the floppy drive light will go off.)	

Fig. 29

Export Setup Parameters

Check Here to Confirm Export

Enter Name of Table to Export

Enter Full Path Name of Data Destination  
(incl. drive specifications, directory name  
& file name eg. C:\excel\JanAcc.txt)

Fig. 32

Open Claim?

Disabling Claim?

Investigation Required?

Fig. 33

is a "First Report of Injury" Required?  Yes  No

Fig. 30

Accident Form	
RECORD LOOKUP: <input type="text"/>	Accident #: <input type="text" value="82"/>
<input type="button" value="◀◀"/> <input type="button" value="▶▶"/> <input type="button" value="EDIT"/> <input type="button" value="DELETE"/> <input type="button" value="NEW"/> <input type="button" value="CLOSE"/> <input type="button" value=" OVERRIDE"/>	
Name Lookup: <input type="text"/>	
Vital Information	Emp. ID: <input type="text"/> Soc. Sec. Number: <input type="text"/> 1234567 <input type="text"/> 123-45-6789 <input type="text"/>
First: <input type="text"/>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Last: <input type="text"/>	Birthdate: <input type="text"/>
Address: <input type="text"/>	City: <input type="text"/>
Adj. Hire Date: <input type="text"/> 21/4/77 <input type="text"/> 17 YRS. 8 MOS. <input type="text"/>	State: Zip: <input type="text"/> Phone Number: <input type="text"/> 999 <input type="text"/>
Worker Occupation: <input type="text"/> JANITOR <input type="text"/>	Company: <input type="text"/> OFFICE <input type="text"/>
Dept. #: <input type="text"/> 2 <input type="text"/>	Department Name: <input type="text"/> BlueJays <input type="text"/>
Team Code: <input type="text"/> 6 <input type="text"/>	Team Name: <input type="text"/> BlueJays <input type="text"/>
Page Down <input type="button"/>	Accident Specifics <input type="button"/>
Page Bottom <input type="button"/>	OSHA Info. <input type="button"/>

Fig. 31

Accident Specifics		Date of Injury: <input type="text" value="2/11/95"/>	Time of Injury: <input type="text"/>
Hospitalized: <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Hospital: <input type="text"/>	Physician: <input type="text"/>
Body Part Afflicted: <input checked="" type="checkbox"/> RIGHT <input type="checkbox"/> WRIST(S) <input checked="" type="checkbox"/> LEFT		Body Part Previously Injured? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If Yes, Explain: <input type="text"/>	
Nature of Injury: <input type="text" value="FRACTURE"/>		Incident Type: <input type="text"/>	POOR LIGHTING <input type="checkbox"/>
Contrib. Cause: <input type="text" value="HORSEPLAY"/>		Conditions: <input type="text"/>	SLIPS & FALLS <input type="checkbox"/>
Company Accident Description		Adv. Info. <input type="text"/>	
Corrective Action Taken		Date Completed: <input type="text"/>	Is a "First Report of Injury" Required? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> Page Up <input type="checkbox"/> Page Down
			<input type="checkbox"/> Vital Statistics <input type="checkbox"/> FROI & OSHA Info.
			<input type="checkbox"/> Open Claim? <input type="checkbox"/> Disabling Claim? <input type="checkbox"/> Investigation Required? <input checked="" type="checkbox"/>

Fig. 34

Reference: <input type="text"/>	Primary Cause: <b>HORSEPLAY</b>	Secondary Causes: <b>Caught in, Under, Between</b>	Primary Condition: <b>POOR LIGHTING</b>	Secondary Conditions: <b>EXCESSIVE EXPOSURE</b>	Primary Witness: <input type="text"/>	Supplemental Witnesses: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Summary: <input type="text"/>
<b>Accident Report - Advanced Information</b>				<b>Return</b>			

Fig. 35

Employee Accident Description If version does not differ from Co. Description, copy & paste from above

Fig. 36

First Report of Injury - State Exceptions	
In addition to the information already provided, your state also requires the following:	
<input type="button" value="RETURN"/>	
OSHA CASE #:	<input type="text"/>
Case #:	<input type="text"/>
Employee Class Code:	<input type="text"/>
Value of other payments not recorded:	<input type="text"/>
Gross Wages/Salary:	<input type="text"/>
Employer Type:	<input type="text"/>
Hospital Address:	<input type="text"/>
Physician's Address:	<input type="text"/>
What was worker doing at the time of Injury?:	<input type="text"/>
What equipment /material was the employee using during time of Injury?:	<input type="text"/>
Employee Policy #:	<input type="text"/>
Was Salary Continued?:	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
Paid full wages for day of Injury?:	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
If a fatality, what is the date of death?:	<input type="text"/>

Fig. 37

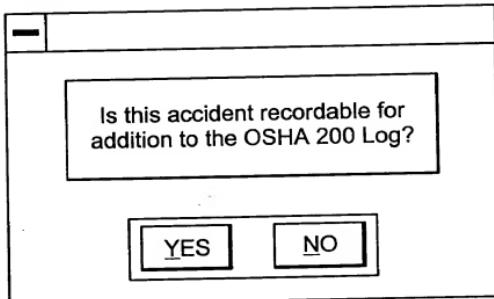


Fig. 38

Accident Report Recap:

WHAT: **Fracture**   Wrist(s)    LEFT    RIGHT

WHEN: **12/17/94**   HOW LONG:   

HOW BAD:  FATALITY?   Date Left:   Date Returned:

Company Accident Description:

Enter a Unique Case Number:

Push to enter info in Correct Category

Injury Related    Illness Related

OSHA 200 Form Accident Description:

PAGE TOP   Vital Statistics   PAGE UP   FROI & OSHA Info.

Fig. 39

Injury Related		Nonfatal Injuries		Injuries Without Lost Workdays		Injuries With Lost Work Days	
Fatalities							
	Injury Related Enter DATE of death.	Enter Mo/da/yr	Enter a CHECK if injury involves days away from work, or days of restricted work activity or both.	Enter a CHECK if injury involves days away from work.	Enter number of DAYS away from work.	Enter number of DAYS of restricted work activity.	Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above.
(1)	(2)	(3)	(4)	(5)	(6)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PAGE TOP		Vital Statistics	
				PAGE UP		OSHA 200 LOG Info.	

Fig. 40

(7) Type of Illness		Check only one column for each illness			
		Occupational Skin Diseases or Disorders <input type="checkbox"/> (a)		Disorders Due to Physical Agents <input type="checkbox"/> (e)	
		Dust Diseases of the Lungs <input type="checkbox"/> (b)		Disorders Associated with Repeated Trauma <input type="checkbox"/> (f)	
		Respiratory Conditions Due to Toxic Agents <input type="checkbox"/> (c)		All Other Occupational Illnesses <input type="checkbox"/> (g)	
Illness Related		Illnesses Without Lost Workdays			
Fatalities		Nonfatal Illnesses		Illness With Lost Work Days	
Illness Related	Enter a CHECK if illness involves days away from work, or days of restricted work activity or both.	Enter a CHECK if illness involves days away from work.	Enter number of DAYS away from work.	Enter number of DAYS of restricted work activity.	Enter a CHECK if no entry was made in columns 1 or 2 but the illness is recordable as defined above.
(8)	(9)	(10)	(11)	(12)	(13)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fig. 41

Advanced Accident Investigation:					
RECORD LOOKUP:	<input type="text"/> 1	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	CLOSE	Accident ID	<input type="text"/> 86
<b>Report Overview</b>					
Enter any investigation report # <input type="text"/> 5342					
Name:	<input type="text"/>	<input type="text"/>	SSN:	DOB:	<input type="text"/>
10/17/94	<input type="text"/>	<input type="text"/>	Male	<input type="checkbox"/>	Company
Date:	<input type="text"/>	<input type="text"/>	Female	<input type="checkbox"/>	Dept. Name:
Location:	<input type="text"/>	<input type="text"/>	999	<input type="checkbox"/>	6 months
Description	Employee's right arm was amputated				
Report Status	<input type="checkbox"/> Initial Report	<input type="checkbox"/> Investigation	<input type="checkbox"/> Cause	<input type="checkbox"/> P.Action	<input type="checkbox"/> Acknowl.
Nature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Completed
Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C.Action	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
BodyPart	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Incid.Type	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Incident Investigation					
Training & Special Info.					

Fig. 42

Investigation Support	
WHAT	Break
WHERE	
WHAT KIND	
BODY PART	Arm(s) L <input type="checkbox"/> R <input checked="" type="checkbox"/> ?
HOW LONG?	
COUNT	4
WHEN	10/17/94
CONDITION	0
HOW BAD?	0
OSHA status	6
-TO-	
COUNT	2
WHEN	8:00:00 a.m.
CONDITION	Confined Space
HOW BAD?	FATALITY: <input type="checkbox"/>
OSHA status	HOSPITALIZED: <input type="checkbox"/>
-TO-	
Employee's right arm was amputated.	
Accident Description:	Nothing.
Corrective Action Description:	10/18/94
Probable Root Cause:	Hazard
Report Overview	
Training & Special Info.	

Fig. 43

Training History			
Class Name	Class Date:	Re-Training:	
Basic CPR	1/16/95	5/16/95	
Basic CPR	5/17/94	9/14/94	
Basic CPR	6/14/94	10/12/94	
Accident History			
Date	Nature of Injury	Body Part	Incident Type
12/2/94	Bruise	Ankle(s)	Struck By
Have changed policies re: accident procedures			
Preventative Action Taken:			
Corrective Action Assigned to:			
Report Overview			
Advanced Investigation			
Performance Analysis			
Co. Avg. #pp	Acc total this pp	100.00%	Individual Performance
2	2		

Fig. 44

Accident Related Information  
Date of Corrective Action Review Form  
Date of Corrective Action Review Form  
||| Lookup:

Date of Injury	Name	Nature & Type of Injury	Corrective Action Taken
1/8/97	Employee Name	Bruise	
6/11/92	Employee Name	Lock Out / Tag Out	
4/11/93	Employee Name	Asphyxiation	
		Respiratory Protection	
		Eye	
		Eye Protection	
1/14/94	Employee Name	Thermal/Chemical Burn	Have shut down the furnaces and ordered repairs made.
2/11/94	Employee Name	Lock Out / Tag Out	
		Burn - Chemical/Illness	
		Hazardous Materials	

Fig. 45

TRAFFIC ACCIDENT AND INSURANCE REPORT	
Accident #	3
Lookup:	<input type="text"/> <input type="button" value="▼"/> <input type="button" value="▲"/> <input type="button" value="◀"/> <input type="button" value="▶"/> <input type="button" value="SAVE"/> <input type="button" value="DELETE"/> <input type="button" value="ADD"/> <input type="button" value="CLOSE"/>
Press to Select	
<b>REPORT DIRECTORY</b>	
Employee Lookup:	<input type="text"/> <input type="button" value="▼"/>
Employee Name and SS#	<input type="text"/> <input type="button" value="▼"/>
<b>VEHICLE #1</b>	
Driver	<input type="button" value="Vehicle Info"/>
Passengers	<input type="button" value="Insurance Info"/>
<b>VEHICLE #2</b>	
Driver	<input type="button" value="Vehicle Info"/>
<i>If Accident involved someone outside of a motor vehicle, answer the following questions.</i>	
<b>INFORMATION OTHER:</b>	
Involved Pedestrian	<input type="checkbox"/>
Involved Bicyclist	<input type="checkbox"/>

Fig. 49

1ST Quarter			
January	February	March	
0	0	0	0
<input type="button" value="OK"/>	<input type="button" value="Cancel"/>		

Fig. 46

FIG. 47

Team Status Change - Quick Entry Screen

LAST	FIRST	SSN	DOB	HIRE	CODE	Team Name
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles
Last-name	First-name	123-45-6789	01/23/45	12/30/89	4	Eagles

Lookup:  CLOSE

Fig. 48

Monthly Safety Admin. - Hours Worked Entry Form					
Year Lookup:	<input type="text"/>	<input type="button" value="▼"/>	<input type="button" value="▲"/>	<input type="button" value="EDIT"/>	<input type="button" value="DELETE"/>
Company Name:	<input type="text"/>	<input type="button" value="▼"/>	<input type="button" value="▲"/>	Plant Location#:	<input type="text"/> 999 <input type="button" value="▼"/>
Submitted To:	<input type="text"/> 1				
THIS REPORT COVERS THE FISCAL YEAR LISTED BELOW:					
<input type="text"/> 1993					
Authorization / Routing					
Production Manager:					
Purchasing Manager:					
General Manager:					
Select Quarter					
<input type="text"/> 1st Quarter <input type="text"/> 2nd Quarter <input type="text"/> 3rd Quarter <input type="text"/> 4th Quarter					

Fig. 50

S.O.S. Report Form	
Report Basics:	<input type="text"/> <input type="button" value="Lookup"/> <input type="button" value="Delete"/> <input type="button" value="Edit"/> <input type="button" value="Add"/> <input type="button" value="Close"/> <input type="button" value="Override"/>
Report ID:	<input type="text"/> <input type="button" value="Delete"/>
Reported By:	<input type="checkbox"/> Company Employee <input type="checkbox"/> Non Employee
If reported by a company employee, use the "name lookup" box below, to select the person's name who is reporting	
Name Lookup:	<input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/> <input type="text"/> <input type="button" value="Delete"/>
Mail Stop / Location	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Company	<input type="checkbox"/>
Affected Persons	(If different than above i.e. contractor, visitor, etc.) <input type="text"/>
Page Down	<input type="button" value="Down"/>
Incident Specifics	<input type="text"/>

Fig. 51

Incident Specifics	Date Observed: _____	Time: 10:00 A.M.
Incident Location:	Incident Type: _____	
Incident Nature:	Break	Conditions: Faulty Floor or Surface
Incident Description	Witness: _____	
Corrective Action Taken <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      If Yes complete the following information		
Description: _____		
Date Completed: _____		
Did you involve your supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No      Their Name: _____		
Is further action needed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, suggestions: _____		
Page Up		Report Basics

Fig. 52

S.O.S. Investigation			
Lookup: <input type="text"/>	<input type="button" value="Initial Report"/>	<input type="button" value="Affected Persons:"/>	<input type="button" value="Description:"/>
Report Overview		Report Status	
Submitted By: <input type="text"/> Name: <input type="text"/>	Initial Report <input type="checkbox"/> Nature <input type="checkbox"/> Date <input type="checkbox"/> C.Action <input type="checkbox"/> Supvr.	Affected Persons: <input type="checkbox"/> Action Nd.	Completed <input type="checkbox"/> Cause <input type="checkbox"/> P.Action <input type="checkbox"/> Acknowl.
Address: <input type="text"/> Mail Stop / Location: <input type="text"/>	Report ID: <input type="text"/> 1005 <input type="checkbox"/> Company Employee <input type="checkbox"/> Non Employee	State: <input type="text"/> Zip: <input type="text"/>	Investigation <input type="checkbox"/> Incident <input type="checkbox"/> Investigation
Description: <input type="text"/>		Action & Response: <input type="text"/>	

Fig. 53

Training - Enrollment Form					
Class Lookup:	<input type="text"/>	<input type="button" value="◀"/>	<input type="button" value="▶"/>	<input type="button" value="■"/>	<input type="button" value="CLOSE"/>
CODE:	<input type="text"/>	SUBJECT:			
CPR 101	Basic CPR	Basic CPR Technique Training			
Date:	<input type="text" value="5/17/94"/>	Instructor:	<input type="text"/>		
Location:	<input type="text"/>	Test ID:	<input type="button" value="Advanced CPR"/>	<input type="button" value="◀"/>	<input type="button" value="▶"/>
Attendees:					
	Name Lookup	Last	Last	Dept. Name	Company
▶	Full Name - SSN	<input type="button" value="◀"/>	Last Name	First Name	Office
	Full Name - SSN	Last Name	First Name	Office	Company Name
	Full Name - SSN	Last Name	First Name	Office	Company Name
	Full Name - SSN	Last Name	First Name	Office	Company Name
	Full Name - SSN	Last Name	First Name	Office	Company Name
	Full Name - SSN	Last Name	First Name	Office	Company Name
◀	Record: 1	<input type="button" value="◀"/>	<input type="button" value="▶"/>	<input type="button" value="◀"/>	<input type="button" value="▶"/>

Fig. 54

## RE-TRAINING - Enrollment Form

Class Lookup:

CODE:  SUBJECT:  Re-Training Interval:

CPR 101  Basic CPR Date:  4/1/94

Instructor:

Basic CPR Technique Training  Four Months

Location:

Test ID:

>>Next Date:  Create New Date:

<<Prev. Date:

Attendees:

Name	Lookup	Last	Last	Dept. Name	Company
<input type="text"/>	<input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Record: 1

Fig. 55

<b>Create Or Modify a test</b>	
Locate a Specific Test <input type="button" value="Down"/> or <input type="button" value="New"/>	
Test Name	Advanced CPR
Test Subject	Advanced CPR Training
Question: When performing CPR, what is the correct ratio of "breaths" to "beats?" <input type="button" value="Previous Question"/> <input type="button" value="Next Question"/>	
ANSWERS	
<input type="radio"/> A. 5 breaths to 2 beats <input checked="" type="radio"/> B. 2 breaths to 5 beats <input type="radio"/> C. 4 breaths to 3 beats	

Fig. 56

Score a Test		
Session ID	Test Advanced CPR Student	<input type="button" value="Go to Test Entry Screen"/> <input type="button" value="Close"/>
Number	Answer	Score
1	2	10
2	1	0
3	1	10
4	1	10
0	1	

Question

Correct Responses		
1	2	10 When performing CPR, what is the (2 10) B, 2 breaths to 5 Beats
2	1	0 Before performing CPR, you should (2 10) FALSE
3	1	10 You should open a victim's mouth (1 10) TRUE
4	1	10 How long should you continue the (1 10) A - Until professional m

Fig. 57

Test Question Summary			
Test Advanced CPR	Modify This Test		
Advanced CPR Training			
#	Question	Answer	Points
1	When performing CPR, what is the correct ratio of for "b	B. 2 breaths to 5 Beats	10
2	Before performing CPR, you should move the person	FALSE	10
3	You should open a victim's mouth and check for obstruct	TRUE	10
4	How long should you continue the procedure once it i	A. Until professional medical	10

Fig. 58

<b>Cost of Accident</b>	
III Lookup: <input type="text"/>	
<input type="button" value="◀▶"/> <input type="button" value="CLOSE"/>	
<b>Vital Information</b>	
Last: <input type="text"/>	
First: <input type="text"/>	
Date of Birth: <input type="text"/> 5/14/47 <input type="text"/> Soc. Sec. #: <input type="text"/>	
<b>Accident Report Recap:</b>	
Date of Injury	10/17/94 <input type="text"/> Break <input type="text"/> Nature of Injury <input type="text"/> Body Part <input type="text"/> Lock Out / Tag Out <input type="checkbox"/> Fatality? <input type="checkbox"/>
Description:	Employee's right arm was amputated.
<b>Accident Costs:</b>	
Direct Medical Costs:	<input type="text"/> \$500.00
Compensation Costs:	<input type="text"/> \$100.00
Administration Costs:	<input type="text"/> \$120.00
Initial Accident Costs:	<input type="text"/> \$720.00
Estimated Reserves:	<input type="text"/> \$2,000.00

Fig. 59

Worker's Compensation Analysis - Setup Form

CLOSE

Name of Primary Product	Plastics
Avg. Retail Cost per Unit	\$15,000.00
Avg. % of Profit per Unit	20.00%
# Mfg. Days Req. per Unit	1

◀ Record: 1 ▶

Fig. 60

### Advanced Tracking - Entry Screen

|| LOOKUP:

Soc. Sec. Number:  Name Lookup:

Last	<input type="text"/>	First	<input type="text"/>	Adj. Hire Date:	<input type="text"/> 7/1/77	17yrs-3mos	<input type="text"/> 5	Retail
				L.O.E.:				
				Dept. #:	<input type="text"/>	Dept. Name:		

Date Absent:  1/13/94 Date Returned:  1/28/94 Absence Code:  Unexcused

Corrective Action  Required?  Associate placed on notice of suspension  
 Action Taken:  of privileges

Fig. 61

OSHA 200 Information	
Record Lookup: <input type="text"/>	<input type="button" value="▼"/> <input type="button" value="▲"/> <input type="button" value="◀"/> <input type="button" value="▶"/> <input type="button" value="CLOSE"/> <input type="button" value="DELETE"/>
Enter a Case Number: <input type="text"/>	
Vital Information	
Name: <input type="text"/>	Date of Birth: <input type="text"/> Soc. Sec. #: <input type="text"/> Date of Injury: <input type="text"/>
6/18/81 Date of Hire:	13yrs - 6mos L.O.E.: <input type="text"/>
Time in Dept: <input type="text"/>	Occupation: <input type="text"/>
Department: <input type="text"/> 5	Retail Dept. Name: <input type="text"/>
Accident Recap <input type="button" value="Injury Related"/> <input type="button" value="Illness Related"/>	

Fig. 62

Accident Report Recap:					
WHAT	Fracture	Wrist(s)	<input type="checkbox"/> LEFT	<input checked="" type="checkbox"/> RIGHT	
WHEN	12/17/94	HOW LONG			
HOW BAD	<input type="checkbox"/> FATALITY?		Date Left:		Date Returned:
Company Accident Description			Enter a Unique Case Number: <input type="text"/>		
			<input type="button" value="Push to enter info in Correct Category"/> <input type="checkbox"/> Injury Related <input type="checkbox"/> Illness Related		
OSHA 200 Form Accident Description			<input type="text"/>		
<input type="button" value="PAGE TOP"/>		Vital Statistics		<input type="button" value="PAGE UP"/> FROI & OSHA Info.	

Fig. 66

<b>OSHA - First Report of Injury</b>	
Select Accident File <input style="width: 150px; border: 1px solid black; border-radius: 5px; padding: 2px 10px; margin-right: 10px;" type="text"/> <input style="border: 1px solid black; border-radius: 5px; padding: 2px 10px;" type="button" value="..."/>	
<b>CONFIRMATION</b>	
<u>Last Name</u>  <input style="width: 250px; border: 1px solid black; border-radius: 5px; height: 40px;" type="text"/>	<u>Date of Injury</u>  <input style="width: 250px; border: 1px solid black; border-radius: 5px; height: 40px;" type="text"/>
<b>OPTIONS</b>	
<input style="border: 1px solid black; border-radius: 5px; padding: 5px 20px;" type="button" value="Print Preview"/>	<input style="border: 1px solid black; border-radius: 5px; padding: 5px 20px;" type="button" value="Print"/>
<input style="border: 1px solid black; border-radius: 5px; padding: 5px 20px;" type="button" value="CANCEL"/>	

Fig. 63

Injury Related		Injuries Without Lost Workdays			
Fatalities	Nonfatal Injuries	Injuries With Lost Work Days			
Injury Related Enter DATE of death.	Enter a CHECK if injury involves days away from work, or days of restricted work activity or both.	Enter a CHECK if injury involves days away from work.	Enter number of DAYS away from work.	Enter number of DAYS of restricted work activity.	Enter a CHECK if no entry was made in columns 1 or 2, but the injury is recordable as defined above.
Mo/da/yr (1)	(2)	(3)	(4)	(5)	(6)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 0	<input type="checkbox"/>	<input type="checkbox"/>

Fig. 64

Accident Report by Period	
<b>Related Categories</b>	Select report data criteria from any or all of the below listed categories
Nature of Injury	<input type="text"/>
Accident Type	<input type="text"/>
Cause	<input type="text"/>
Condition	<input type="text"/>
Body Part	<input type="text"/>
Enter the report START and END dates	
START	<input type="text"/>
END	<input type="text"/>
To further customize your report, one or all of the following may be selected	
Company	<input type="text"/>
Division / Plant	<input type="text"/>
Department	<input type="text"/>
OPTIONS	
Print	<input type="text"/>
Preview	<input type="text"/>
CANCEL	

Fig. 65

<b>Accident Analysis - Parameter Defined</b>	
<b>Related Categories</b>	Select report data criteria from any or all of the below listed categories
<b>Nature of Injury</b>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Accident Type</b>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Cause</b>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Condition</b>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Body Part</b>	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Report Period</b>	
Enter the report START and END dates	
<input type="text"/> <input type="text"/> <input type="text"/>	<b>START</b>
<input type="text"/> <input type="text"/> <input type="text"/>	<b>END</b>
To further customize your report, one or all of the following may be selected	
<input type="text"/> <input type="text"/> <input type="text"/>	<b>Company</b>
<input type="text"/> <input type="text"/> <input type="text"/>	<b>Division / Plant</b>
<input type="text"/> <input type="text"/> <input type="text"/>	<b>Department</b>
<b>OPTIONS</b>	<b>Print</b>
<b>Print Preview</b>	<b>CANCEL</b>

Fig. 67

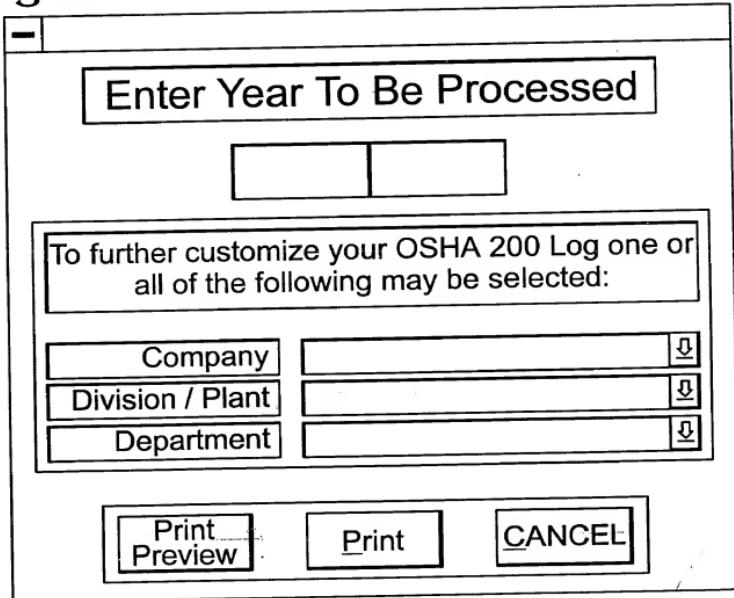


Fig. 68

OSHA Year End Questionnaire

Enter Year To Process

Enter Starting Month:

Enter Ending Month:

Starting Day:

Ending Day:

Optional. If left blank, all days will be displayed

OPTIONS

Print Preview

Print

CANCEL

Fig. 69

Accident Related Graphs	
<p>Enter Year to Process</p> <p>_____ -to- _____</p>	<p>Press to Select Multi-Yr Comparisons</p> <p>_____</p>
<p>Select Graph to Open:</p> <p><input type="radio"/> Accident Reminders</p> <p><input checked="" type="radio"/> PCT. By Dept.</p> <p><input type="radio"/> Body Parts</p> <p><input type="radio"/> Costs / Hi-to-Lo</p> <p><input type="radio"/> Departments</p> <p><input type="radio"/> Freq. By Day of the Week</p> <p><input type="radio"/> Freq. By Time of the Day</p> <p><input type="radio"/> Injuries Avg. Cost</p> <p><input type="radio"/> Length of Emp.</p> <p><input type="radio"/> Monthly Totals</p> <p><input type="radio"/> Nature of Injury</p>	<p>Description:</p> <p>Option:</p> <p>Preview</p> <p>Print</p> <p>Design</p> <p>To further customize your graphs, one or all of the following may be selected</p> <p>Company _____</p> <p>Division / Plant _____</p> <p>Department _____</p>

Fig. 70

Accident Related Graphs	
<p>Enter Year to Process</p> <p>_____ -to- _____</p>	<p>Press to Select Multi-Yr Comparisons</p> 
<p>Select Graph to Open:</p> <p><input type="radio"/> Accident Reminders</p> <p><input type="radio"/> Body Parts</p> <p><input type="radio"/> Condition Type</p> <p><input type="radio"/> Costs / Hi to Lo</p> <p><input type="radio"/> Departments</p> <p><input type="radio"/> Freq. By Day of the Week</p> <p><input type="radio"/> Freq. By Time of the Day</p> <p><input type="radio"/> Incident Types</p> <p><input type="radio"/> Injuries Avg. Cost</p> <p><input type="radio"/> Monthly Totals</p>	<p>Description:</p> <p><input type="radio"/> Preview</p> <p><input type="radio"/> Print</p> <p><input type="radio"/> Design</p> <p>To further customize your graphs, one or all of the following may be selected</p> <p><input type="radio"/> Company</p> <p><input type="radio"/> Division / Plant</p> <p><input type="radio"/> Department</p>

Fig. 71

<b>MASTER COST ANALYSIS</b>	
<b>Related Categories</b>	Select report data criteria from any or all of the below listed categories
<input type="checkbox"/> Nature of Injury	<input type="checkbox"/> Accident Type
<input type="checkbox"/> Cause	<input type="checkbox"/> Condition
<input type="checkbox"/> Condition	<input type="checkbox"/> Body Part
<input type="checkbox"/> Body Part	
Enter the report START and END dates	
<input type="checkbox"/> START	<input type="checkbox"/> END
Report Period	
To further customize your report, one or all of the following may be selected	
<input type="checkbox"/> Company	<input type="checkbox"/> Division / Plant
<input type="checkbox"/> Department	
<input type="checkbox"/> OPTIONS	<input type="checkbox"/> Print
<input type="checkbox"/> Print Preview	<input type="checkbox"/> CANCEL